

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36578

State File No.

Registrar's No.

9705

Registration District No.

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 day's  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Anna Kroeper

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widow

6. (b) Name of husband or wife Frank Kroeper 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased February 6, 1854  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
89 8 28 hr. .... min.

9. Birthplace Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business.....

12. Name Joseph Haaser 13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Alice A. Schneider

(b) Address 3816 Ashland Ave.

17. (a) Burial (b) Date thereof Nov. 8, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethany Cemetery

18. (a) Signature of funeral director Paschedag-Henke Fun. Home

(b) Address 2825 N. Grand Ave.

19. (a) NOV 5 1943 (b) J. J. Bredeck  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3623 Sullivan Ave.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4th  
year 1943 hour 7 minute 30A M.

21. I hereby certify that I attended the deceased from Jan. 10-40 to Nov. 4, 1943  
that I last saw her alive on Nov 3, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

Chronic Endocarditis

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

Home (Specify type of place)

While at work? (e) Means of injury.....

23. Signature D. A. Thomson (M. D. or other)

Address 3121 Laurel St. Date signed 11-5

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*J. Allen Davis Jr.*  
4053

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**